State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
(916) 263-2382 FAX (916) 263-2567
www.medbd.ca.gov

APPLICATION FOR VOLUNTARY SURRENDER OF LICENSE

Please print or type.
Illegible applications will be returned.

FOR OFFICE USE ONLY

Date Received

Enforcement Approval: Yes____No____Date_____

Initials:_____

Name (first, middle, last):	
Address: This address will be on file with the Medical Board of California and is public information. If providing PO Box, you must also list a confidential street address.	
Telephone Number:	Telephone: ( ) FAX: ( )
Date of Birth	
Sacral Security Number:	
California Medical License Number:	

Once this form is properly completed and approved, you will be notified of the date your license will be canceled. Once canceled it may not be renewed, reissued, reinstated or restored. If you later decided to become licensed in the State of California, you will be required to apply far a new license and will be subject to the requirements in effect at the time of application. This may include a written and/or oral examination.

THIS OPTION MAY NOT BE AVAILABLE IF YOU ARE CURRENTLY UNDER INVESTIGATION BY THE MEDICAL BOARD OR IF THE MEDICAL BOARD HAS INITIATED DISCIPLINARY ACTION AGAINST YOUR LICENSE.

PLEASE SUBMIT YOUR ORIGINAL WALL CERTIFICATE AND THE LAST ORIGINAL LICENSED ISSUED

This request for voluntary surrender of license must be accompanied by the your original Wall Certificate and the last original license issued. It the Wall Certificate and/or last original license are no longer it your possession, please provide below a brief explanation as to the reason the license is no longer in your possession.

_____

_____

I certify under penalty of perjury under the laws of the State of California, that the information contained in this application, including supporting documents is true and correct

_____ _____
Applicant's Signature Date

All items in this application are mandatory; none are voluntary. This information is requested by the Division of Licensing of the Medical Board of California. Failure to provide any of the requested information will result in the application being rejected as incomplete. The Licensing Program Chief Program is the custodian of records. Access to records by the individual to whom they pertain may be obtained under the Information Practices Act by contacting the custodian of records at the above address. Information in this application may be transferred to other governmental and law enforcement agencies.

Disclosure of your Social Security Number (SSN) or Federal Employer Identification Number (FEIN) is mandatory. Section 30 of the Business and Professions Code and Public Law 94.455 (42 U.S.C.A 405 (c) (2) (C)) authorize collection of your SSN. Your SSN of FEIN will be used for tax enforcement purposes, for purposes of compliance with any judgment a order for family support in accordance with Section 17520 of the Family Code, or for verification of licensure or examination status by a licensing examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your SSN or FEIN, your application will not be processed and you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.